Smile FOR A Lifetime Foundation

DENTAL CLEARANCE FORM

Dear Dental Care Provider,

Your patient is applying for an orthodontic scholarship through the Smile for a Lifetime program. The charity is a nationwide program that provides scholarships for orthodontic treatment to children who may not have the means to afford care. As a dental care provider, it is very important we receive feedback from you in regards to your patient so we can determine whether or not they will be a good candidate for our program.

To be filled out by the applicant's dentist.

Patient Name: _____
Last First

Dentist's Name: _____

Dental Practice Address _____

Dental Practice Phone Number: _____

GENERAL INFORMATION

Does the patient have a need for orthodontic treatment? **Yes No** _____

Functional or Aesthetic Issues/ Additional Comments: _____

_____

Is there any dental work needed before the patient begins orthodontic treatment? Is so,please explain: _____

_____

Does the patient have good oral hygiene? Yes No Date of last cleaning: _____

How long have you been treating the patient: _____

Does the patient have a positive and respectful attitude: _____

Does the patient keep appointments: (please circle one) Always Mostly Sometimes Rarely Never

Name of staff member completing this form (please print) _____

ADDTIONAL INFORMATION :

_____

_____

_____

Please return by email to info@SmileForALifetime.org or Fax to 719-312-6000